STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G217 07/28/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **617 DAHLIA STREET, NW** RCM OF WASHINGTON, INC. WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX COMPLETE. REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) 1000 INITIAL COMMENTS 1000 On May 20, 2009, the Health Regulation Administration (HRA) received an incident report via fax transmittal. According to the incident report, Resident #1 was on a routine appointment at a wound care clinic that day when clinicians OF THE DISTRICT OF COLUMBIA observed signs/symptoms of infection on the DEPARTMENT OF HEALTH client's right heel. The resident was taken to a HEALTH REGULATION ADMINISTRATION hospital emergency room for evaluation, and was 825 NORTH CAPITOL ST., N.E., 2ND FLOOR subsequently admitted. He was discharged from WASHINGTON, D.C. 20002 the hospital on June 9, 2009 and returned home. On July 27, 2009, HRA initiated an onsite investigation to determine compliance with federal and local standards of care with respect to the provision of health care, wound care and prevention and the establishment and implementation of policies and procedures designed to ensure client health and safety. The findings of this report were based on observation of Resident #1, interviews with nursing staff, direct support staff and administrative staff as well as the review of the resident's medical and physical therapy records. In addition, the resident's incident reports and corresponding ! investigation reports also were reviewed. It should be noted that Resident #1's health care and habilitation services had been reviewed during a March 19, 2009 annual recertification survey. 1422 3521.3 HABILITATION AND TRAINING 1422 Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident 's Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record OR PROVIDERS UPPLIER REPRESENTATIVE'S SIGNATURE U. director

Health Regulation Administration

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Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G217 07/28/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **617 DAHLIA STREET, NW** RCM OF WASHINGTON, INC. WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE **DEFICIENCY**) 1422 Continued From page 1 1422 All staff were inserviced on client #1's review, the facility failed to ensure that residents repositioning on 7-29-09 were repositioned in accordance with their Refer to attachment #1 repositioning schedule, as prescribed, for the one The repositioning form was revised by the resident with multiple pressure sores out of five facility RN. The RN did add the comment section total residents. (Resident #1) in the event that there is discrepancy The findings include: in repositioning time. 9-11-09 Refer to attachment #2 On July 27, 2009 at 8:35 a.m., Resident #1 was In the future, the facility will ensure that observed lying in bed, positioned on his back client #1 is repositioned, and that facing the ceiling. At the time, there was an LPN and at least two direct support staff on duty in the any discrepancy in time is documented: facility. The LPN stated that she had been on in addition, the facility will only maintain one duty since approximately 8:00 a.m. that morning. log book. in accordance with her scheduled shift. It can be noted that the staff closed the door According to staff, and later verified through for privacy as they were about to provide record review, Resident #1 was totally dependent care to client #1. on staff for repositioning. At approximately 8:50 a.m., the house manager arrived in the facility. At 8:55 a.m., someone closed the resident's bedroom door as this surveyor walked towards the door. The resident's position at that time was not determined immediately. At approximately 9:30 a.m., the LPN stated that the resident had a wheelchair and he was sitting in it at that time. [This was confirmed through observation.] She further indicated that there was an established schedule for repositioning him around the clock. Staff used the same positioning schedule every day. At approximately 4:55 p.m., review of a repositioning schedule posted on a wall next to the resident's bed revealed that he should have been transferred from his bed into his wheelchair at 8:00 a.m. His orders were to have him repositioned every two Beginning at approximately 4:57 p.m., the QMRP and the supervisory RN were asked about the

Health Regulation Administration

FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G217 07/28/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 617 DAHLIA STREET, NW RCM OF WASHINGTON, INC. WASHINGTON, DC 20011 **SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) 1422 Continued From page 2 1422 All staff were inserviced on client #1's repositioning schedule. To their knowledge, staff repositioning on 7-29-09 had been adhering to the posted schedule. They Refer to attachment #1 were not aware of any delays or variations in his The repositioning form was revised by the repositioning. After hearing that the resident had been observed in his that morning after 8:30 facility RN. The RN did add the comment section a.m., the RN telephoned the house manager to in the event that there is discrepancy ask about it. She confirmed that he had been in in repositioning time. 9-11-09 bed at the time she arrived that day. Direct Refer to attachment #2 support staff had just returned to the facility from the morning van run to residents' day programs. In the future, the facility will ensure that They closed his bedroom door for privacy during client #1 is repositioned, and that personal hygiene care and then placed the any discrepancy in time is documented; resident in his wheelchair afterwards. in addition, the facility will only maintain one log book. At approximately 5:12 p.m., review of two log books that were being maintained simultaneously It can be noted that the staff closed the door by direct support staff revealed that neither loa for privacy as they were about to provide required staff to document the time that they care to client #1. actually performed the repositioning. Instead, the log sheets had a designated time and position already noted. Staff only had to place their initials in a space next to that repositioning. Review of the log sheet for that morning revealed that staff had placed their initials next to the 8:00 a.m. wheelchair repositioning, even though observations and interviews had shown that the resident remained in bed until 8:50 a.m. or shortly thereafter. The QMRP and the RN acknowledged that they would not have known about the discrepancy in repositioning time had it not been brought to their attention by this surveyor. After more discussion, the QMRP and the RN acknowledged that the current method used by staff to document repositioning did not ensure accurate data for quality assurance purposes.

Health Regulation Administration

It should be noted that Resident #1 had pressure sores on the sacrum, right hip and left hip. A July 16, 2009 report from the wound clinic indicated

Health Regulation Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING **B. WING** 09G217 07/28/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 617 DAHLIA STREET, NW RCM OF WASHINGTON, INC WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION *I*D (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1422 Continued From page 3 1422 that those three wounds were improving. There was no change with the fourth wound (right heal). It should be further noted that the physical therapist had determined 9 months earlier, in October 2008, that the seating system in the resident's wheelchair did not meet the resident's needs. 1500 3523.1 RESIDENT'S RIGHTS 1500 Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: 1. Based on observation, interview and record review, the facility failed to ensure the resident's 719-A form was sent to essential Rehab right to receive a custom seating system suited to his assessed needs, for the one resident in the on 6-10-09; however, Essential did not sample. deliver the wheelchair due to the fact there was no record of the age of the wheelchair. The findings include: Refer to attachment #3 On July 27, 2009 at 9:30 a.m., Resident #1 was A 719-A form was completed, and sent observed seated in a wheelchair in his bedroom. to Essential Rehab 9-14-09 There were pillows placed between both sides of his torso and the right and left sides of the chair. Refer to attachment #4 Beginning at 12:31 p.m., review of the resident's In the future, the facility will ensure that physical therapy (PT) documents revealed that on: client #1 is provided with the adaptive November 17, 2008, the PT recommended a equipment on a timely manner as "new custom seating system" for his wheelchair. d The PT then submitted an assessment tool dated prescribed by the PT. December 29, 2008 that provided specifications regarding the wheelchair molding. Attached was a December 28, 2008 Functional Mobility Evaluation on which the PT wrote "The seating system is oversized and does not support him.

Health Regulation Administration

FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING B. WING 09G217 07/28/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 617 DAHLIA STREET, NW RCM OF WASHINGTON, INC WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE. REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 1500 Continued From page 4 1500 719-A form was sent to Essential rehab on The frame is oversized and forces malalignment 6-10-09; however, Essential Rehab did not <sic>." deliver the wheelchair due to the fact that there was no record of the age of the wheelchair Beginning at approximately 11:40 a.m., review of the qualified mental retardation professional's Refer to attachment #3. (QMRP's) monthly notes revealed for the period Another 719-A form was completed, and January 2009 - June 2009 revealed no sent to Essential Rehab on 9-14-09 references made to the wheelchair and there was Refer to attachment #4 no written documentation of efforts made to In the future, the facility will ensure that secure the new seating system. client #1 is provided with the adaptive At approximately 1:15 p.m., the Director of equipment on a timely manner as prescribed Nursing and the QMRP were asked about the by the PT. status of the custom-molded seating system for the resident's wheelchair. They stated that as of July 27, 2009 he was without the new seating system. A form 719A reportedly had been submitted; however, they could not recall the exact date. They agreed to search for documentation. On July 28, 2009 at 10:35 a.m., the house manager stated that she had instructed staff to hand deliver a 719A form to the PCP's office; this reportedly was achieved on or around July 15. 2009, eight months after the PT recommendation. No written documentation was made available for review before the investigation ended at 5:10 p.m. that evening. It should be noted that in addition to the pressure ulcer on his right heel, Resident #1 was receiving treatment for a pressure ulcer on his right hip, another ulcer on his left hip and yet another pressure ulcer on his posterior sacral area.

Health Regulation Administration

2. Based on observation, interview and record review, the facility failed to develop and implement a system to ensure that Resident #1

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING **B. WING** 09G217 07/28/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 617 DAHLIA STREET, NW RCM OF WASHINGTON, INC WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1500 | Continued From page 5 1500 All staff were inserviced on client #1's was repositioned in accordance with his prescribed repositioning schedule. repositioning on 7-29-09 Refer to attachment #1 The findings include: The repositioning form was revised by the facility RN. The RN did add the comment section Cross-refer to I422. On July 27, 2009 at 8:35 in the event that there is discrepancy a.m., Resident #1 was observed lying in bed. positioned on his back facing the ceiling. At in repositioning time. 9-11-09 approximately 4:55 p.m., review of a repositioning Refer to attachment #2 schedule posted on a wall next to the resident's In the future, the facility will ensure that bed revealed that he should have been client #1 is repositioned, and that transferred from his bed into his wheelchair at any discrepancy in time is documented; 8:00 a.m. His orders were to have him repositioned every two hours. in addition, the facility will only maintain one log book. Beginning at approximately 4:57 p.m., the QMRP It can be noted that the staff closed the door and the supervisory RN were asked about the for privacy as they were about to provide repositioning schedule. To their knowledge, staff care to client #1. had been adhering to the posted schedule. They were not aware of any delays or variations in his repositioning. Review of the log sheet for that morning revealed that staff had placed their initials next to the 8:00 a.m. wheelchair repositioning, even though observations and interviews had shown that the resident remained in bed until 8:50 a.m. or shortly thereafter. The QMRP and the RN acknowledged that they would not have known about the discrepancy in repositioning time had it not been brought to their attention by this surveyor. After more discussion, the QMRP and the RN acknowledged that the current method used by staff to document repositioning did not ensure accurate data for quality assurance purposes.

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NAME OF PROMIDER OR SUPPLIER RCM OF WASHINGTON, INC STREET ADDRESS, CITY, STATE, ZIP CODE 81T DANLAS STREET, NW WASHINGTON, DC 20011 W 000 INITIAL COMMENTS On May 20, 2009, the Health Regulation Administration (HRA) received an incident report vis fax transmittal. According to the incident report, Client #1 was on a routine appointment at a wound care clinic that day when clinicians observed signal-symptoms of infection on the client's right heel. The client was taken to a hospital energency room for evaluation, and was subsequently admitted. He was discharged from the hospital or June 9, 2009 and returned home. On July 27, 2009, HRA initiated an onsite investigation to determine compliance with federal and local standards of care with respect to the provision of health care, wound care and prevention and the establishment and implementation of policies and procedures designed to ensure client health and safety. The findings of this report were based on observation of Client #1, interviews with nursing staff, direct support staff and administrative staff as well as the review of the client's medical and physical therapy records. In addition, the client's incident reports and corresponding investigation reports also were reviewed. It should be noted that Client #1's health care and habilitation services had been reviewed during a March 19, 2009 annual recertification survey. W 159 W 159 W 159 W 159 W 159 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: The propertion of the provision of th	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safegueids provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 159	review, the qualified professional (QMRI implement a system repositioned in according sched client with multiple presidents. (Client # The findings include On July 27, 2009 at observed lying in be facing the ceiling. A	on, interview and record I mental retardation P) failed to develop and n to verify that clients were ordance with their ule, as prescribed, for the one pressure sores out of five total 1)	W '	159	All staff were inserviced on clic repositioning on Refer to attachment #1 The repositioning form was re- facility RN. The RN did add ti in the event that there is discre in repositioning time. Refer to attachment #2 In the future, the facility will er client #1 is repositioned, and the any discrepancy in time is docu in addition, the facility will only log book.	vised by the he comment epancy Insure that hat hat hat	9-11-09
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STREET ADDRESS, CTY, STATE, ZIP CODE 81T DANILLA STREET, WASHINGTON, INC (A4) D SUMMARY STATEMENT OF DEPICIENCES (EACH DEFROCISECY MUST BE PRECEDED BY PULL REGULATORY OR ISC IDENTIFYING INFORMATION) W 159 Continued From page 2 Beginning at approximately 4:57 p.m., the CMRP and the supervisory RN were asked about the repositioning schedule. To their knowledge, staff had been adhering to the posted schedule. They were not aware of any delays or variations in his repositioning. After hearing that the client had been observed in his bed that morning after 8:30 a.m., the RN tolephoned the house manager to ask about it. She confirmed that he had been in bed at the times he arrived that day. Direct aupport staff had just returned to the facility from the morning van run to clients' day programs. They closed his bedroom door for privacy during personal hygiene cares and then placed the client in his wheelchair afterwards. At approximately 5:12 p.m., review of two log books that were being maintained simultaneously by direct support staff revealed that neither log required staff to document the time that ther log required staff to document the time that they greatly performed the repositioning, Instead, the log sheet for that morning revealed that staff had placed their initials in a space next to that respositioning. Instead, the log sheet for that morning revealed that staff had placed their initials in a space next to that respositioning, evelwe of the log sheet for that morning revealed that staff had placed their initials in the decirent remained in bed until 8:50 a.m. or shortly thereafter. The QMRP and the RN acknowledged that they would not have known about the discrepancy in repositioning time. STATE ZEACHORES. SUMMARY STATEMENT OF CROST SECTION SHOULD BE CROSS-REFERENCE ON THE APPROPERATE DEFROILENCE. PREFIX TAG. PREFIX TAG. PREFIX TAG. PREFIX TAG. All staff were inserviced on client #1's repositioning in the facility will ensure that client #1 is repositioned, and that any discrepancy in the faci	09G217			***************************************	l l			
PREFIX TAG REGULATORY OR LISC IDENTEYING INFORMATION) W 159 Continued From page 2 Beginning at approximately 4:57 p.m., the CMRP and the supervisory RN were asked about the repositioning schedule. To their knowledge, staff had been adhering to the posted schedule. They were not aware of any delays or variations in his repositioning. After hearing that the client had been observed in his bed that morning after 8:30 a.m., the RN telephoned the house manager to ask about it. She confirmed that he had been in bed at the time she arrived that day. Direct support staff revealed to the facility from the morning van run to clients' day programs. They closed his bedroom door for privacy during personal hyglene care and then placed the client in his wheelchair afterwards. At approximately 5:12 p.m., review of two log books that were being maintained simultaneously by direct support staff revealed that neither log required staff to document the time that they actually performed the repositioning. Instead, the log sheets had a designated time and position already noted. Staff only had to place their initials next to that repositioning. Review of the log sheets for that morning revealed that staff had placed their initials are to the 8:00 a.m. wheelchair repositioning, even though observations and interviews had shown that the client remained in bed until 8:50 a.m. or shortly thereafter. The QMRP and the RN acknowledged that they would not have known about the discrepancy in repositioning time had it not been brought to their attention by this surveyor. After more discussion, the GMRP and the RN acknowledged that the current method used by staff to document repositioning did not					617 DAHLIA STREET, NW			
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purposes.		Beginning at approximate the supervisory repositioning sched had been adhering were not aware of a repositioning. After been observed in his a.m., the RN telepheask about it. She could be at the time she support staff had just the morning van run. They closed his bed personal hygiene cain his wheelchair aft. At approximately 5:1 books that were bein by direct support staff to doc actually performed to log sheets had a desaiready noted. Staff in a space next to the help sheet for that had placed their initial wheelchair reposition observations and into client remained in bethereafter. The QMI acknowledged that to about the discrepance not been brought to surveyor. After more the RN acknowledge used by staff to docuensure accurate date	cimately 4:57 p.m., the QMRP RN were asked about the ule. To their knowledge, staff to the posted schedule. They my delays or variations in his hearing that the client had is bed that morning after 8:30 and the house manager to confirmed that he had been in arrived that day. Direct is returned to the facility from it to clients' day programs. It com door for privacy during are and then placed the client enwards. 12 p.m., review of two loging maintained simultaneously aff revealed that neither loging ument the time that they he repositioning. Instead, the signated time and position only had to place their initials at repositioning. Review of a morning revealed that staff als next to the 8:00 a.m. ning, even though erviews had shown that the ed until 8:50 a.m. or shortly RP and the RN hey would not have known by in repositioning time had it their attention by this a discussion, the QMRP and ad that the current method incent repositioning did not	W 1	All staff were inserviced on repositioning on Refer to attachment #1 The repositioning form was facility RN. The did add the in the event that there is did in repositioning time. Refer to attachment #2 In the future, the facility will client #1 is repositioned, and any discrepancy in time is did in addition, the facility will log book. It can be noted that the staff for privacy as they were about the staff of the staf	revised by the e comment sector screpancy I ensure that that ocumented; only maintain oclosed the door	9-11-09	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		С	
09G217		B. WING		07/28/2009		
NAME OF PROVIDER OR SUPPLIER RCM OF WASHINGTON, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 617 DAHLIA STREET, NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHI (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
	sores on the sacrur 16, 2009 report fror that those three wo was no change with It should be further therapist had detern October 2008, that client's wheelchair of 483.470(g)(2) SPACThe facility must fur and teach clients to choices about the unhearing and other cand other devices ic	hat Client #1 had pressure n, right hip and left hip. A July n the wound clinic indicated unds were improving. There i the fourth wound (right heal). noted that the physical mined 9 months earlier, in the seating system in the did not meet the client's needs. CE AND EQUIPMENT mish, maintain in good repair, use and to make informed se of dentures, eyeglasses, communications aids, braces,	W 15	719-A form was sent to Es 6-10-09; however, Essenti deliver the wheelchair due was no record of the age of Refer to attachment #3. Another 719-A form was sent to Essential Rehab on Refer to attachment #4 In the future, the facility was sent to Essential Rehab on Refer to attachment #4	al Rehab did not to the fact that there of the wheelchair completed, and 9-14-09 will ensure that the adaptive	
ļ	Based on observation review, the facility facustom seating syst assessed needs, for The findings include On July 27, 2009 at observed seated in a There were pillows phis torso and the rig Beginning at 12:31 physical therapy (PT November 17, 2008, "new custom seating The PT then submitted."	s not met as evidenced by: on, interview and record hiled to secure timely a em to meet a client's r the one client in the sample. 9:30 a.m., Client #1 was a wheelchair in his bedroom. blaced between both sides of hit and left sides of the chair. o.m., review of the client's of documents revealed that on the PT recommended a g system" for his wheelchair. and an assessment tool dated that provided specifications				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 '	IULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
09G217		B. WIN		· 0	C 07/28/2009	
NAME OF PROVIDER OR SUPPLIER RCM OF WASHINGTON, INC				STREET ADDRESS, CITY, STATE, ZIP 6 617 DAHLIA STREET, NW WASHINGTON, DC 20011	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(765) COMPLETION DATE
	a December 28, 20 Evaluation on which system is oversized The frame is oversized The frame is oversized The frame is oversized. The frame is oversized the frame is oversized. The frame is oversized the frame is oversized. The frame is oversized the qualified mental (QMRP's) monthly represented the qualified mental (QMRP's) monthly represented the documentation of elements of the custom the client's wheelch and the custom the client's wheelch and year. A form 719 submitted; however, exact date. They are documentation. On July 28, 2009 at manager stated that hand deliver a 7.19A Physician's (PCP) of achieved on or aroumonths after the PT documentation was before the investigate evening. It should be noted the ulcer on his right heet treatment for a press	Ichair molding. Attached was 08 Functional Mobility of the PT wrote "The seating and does not support him. It is and forces malalignment dimately 11:40 a.m., review of retardation professional's notes revealed for the period is 2009 revealed no references hair and there was no written forts made to secure the new of 15 p.m., the Director of IRP were asked about the in-molded seating system for air. They stated that as of is without the new seating to a written form to the new seating to a reportedly had been at the preed to search for 10:35 a.m., the house is the had instructed staff to form to the Primary Care of iffice; this reportedly was not july 15, 2009, eight recommendation. No written made available for review it is addition to the pressure at in addition to the pressure at in addition to the pressure of the pressure and the pressure an	W 4	719-A form was sent to 6-10-09; however, Esse deliver the wheelchair of was no record of the ag Refer to attachment #3. Another 719-A form w sent to Essential Rehab Refer to attachment #4 In the future, the facility client #1 is provided wite equipment on a timely to by the PT.	ential Rehab did due to the fact the e of the wheelch ras completed, a on y will ensure tha th the adaptive	not nat there hair nd 9-14-09
	It should be noted the ulcer on his right hee treatment for a press	el, Client #1 was receiving				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
09G217		B. WING		_	C 07/28/2009	
NAME OF PROVIDER OR SUPPLIER RCM OF WASHINGTON, INC			61	EET ADDRESS, CITY, STATE, ZIP 7 Dahlia Street, NW (Ashington, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
W 436		ge 5 is posterior sacral area.	W 436			
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